PRINTED: 05/23/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	NVS6117OPF			B. WING		05/10/2011		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	1 00/11	0/2011	
				ARYLAND PKWY #400 AS VEGAS, NV 89031				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
O 000	Initial Comments			O 000				
	This Statement of Deficiencies was generated as a result of a State Permitting Inspection conducted in your facility on 5/10/11, in accordance with Nevada Administrative Code, Chapter 449, Outpatient Facility. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:							
O 080	O 080 Use Of Vials Section 30.			O 080				
	infections and communicable diseas and procedures for si provide that a single-conly by using an asepand procedures must (a) Each injection of a single-dose vial must designated area when bodily fluid is unlikely (b) The medication in be used for more than (c) A single-dose vial, medication in the vial discarded; and (d) Any remaining medication medi	prevention and control ses must include policie ngle-dose vials which dose vial may be acces otic technique. The polic provide that: a medication from a be prepared in a clean re contamination by blo to occur; a single-dose vial mus n one patient; including any remainir	esed cies , ood or t not ng					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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NVS6117OPF				B. WING		05/10/2011		
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
COMPREHENSIVE CANCER CENTERS OF NEVADA			3196 S MARYLAND PKWY #400 NORTH LAS VEGAS, NV 89031					
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O 080	Continued From page 1			O 080				
	medication or otherwise used for any other patients.							
	-		te e y be e. The ned f nge se					
	Based on observation	not met as evidenced b n, interview and docume ed to date and initial 18 cation.	ent					
			ence					

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NVS6117OPF			B. WING		05/10/2011			
				DRESS, CITY, STATE, ZIP CODE				
COMPREHENSIVE CANCER CENTERS OF NEWARA				ARYLAND PKWY #400 AS VEGAS, NV 89031				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
O 080	Continued From page 2			O 080				
O 080	l '		O 080	DEFICIENCY)				